Registration & Insurance Information

Please make sure to read all of the paperwork in its entirety – if you would like a copy of any of your paperwork, please notify your counselor.

Personal Information:

Date: _____

Full Name: _____DOB: _____ Age: _____
SS#_____ Sex: M F T Other: _____Marital Status S M D W

Cell Phone: _____ Address: _____

City: _____State: _____Zip: _____

Alternate Phone: _____ Email Address: _____

Please contact me at: Home/ Cell/ Alternative Phone

How would you like to receive your appointment reminder? Call/ Text via Third Party/ Email

Race: White/Caucasian African-American Asian Latino/Hispanic Native American Multi-Racial Other

Employer: _____Occupation: _____

For Minor Children ONLY:

Full Name: _____DOB: _____ Age: _____

SS#_____ Sex: M F T Other: _____

School: _____ Year: _____

Race: White/Caucasian African-American Asian Latino/Hispanic Native American Multi-Racial Other

Who Referred You? Name: _____Phone: _____

May your therapist acknowledge the referral? Yes No

Emergency Contact: Spouse/Partner/Other: Name: _____ Relationship: _____

Home Phone: _____Cell Phone: _____ Work Phone: _____

Permission to Call? Yes No **Restrictions? _____**

Insurance Information: The office will need both sides of your insurance card. If you are utilizing your company's EAP plan, please make sure you have the name of the EAP and your authorization # to complete below.

Party responsible for payment: Self _____ **Other/Relationship**: _____

Primary Insurance: _____ Phone: _____

Insured Name: _____ **DOB:** _____

ID# _____ **Group #** _____ **Employer**: _____

****Authorization #** (EAP): _____ **Name of EAP:** _____ **# of Sessions:** _____

Secondary Insurance Information: If applicable

Party responsible for payment: Self _____ **Other/Relationship**: _____

Primary Insurance: _____ **Phone:** _____

Insured Name: _____ **DOB:** _____

ID# _____ **Group #** _____ **Employer**: _____

CREDIT CARD/HSA AUTHORIZATION

Please Check One:

VISA____Mastercard_____American Express ____Discover _____ HSA_____ Other_____

Credit Card No._____Expiration Date_____

Security Code_____ Zip Code_____

Cardholder Name (as it appears on card)

_____

Billing Address_____

_____

I _____authorize Jessica Torres-Garcia, LPC, to process the above credit card as "signature on file" for provision of counseling services.

Signature of Cardholder_____Date_____

Phone Number_____Email _____

*If Signature of Cardholder cannot be obtained in person, please complete the following:

I, _____, have been given verbal authorization by
Client Name
_____, to utilize their credit card for counseling services
Cardholder Name

by Jessica Torres-Garcia, LPC.

_____ _____
Client Signature Date

Cell-Phone Disclosure Statement

You may reach us to schedule, reschedule or cancel appointments by leaving a message to whom it may apply. Our normal business hours vary Monday through Friday and alternating weekends. We will try our very best to return your call as soon as possible, but please allow each of us three (3) business days to respond. Please leave times when you can be reached and any alternative phone numbers where you will be available.

Availability times for texting and/or calling are often between the hours of 9:00 AM-9:00PM, Monday through Friday, but due to the nature of text messages, please understand that we cannot protect your confidentiality using this method. Text messages should only include information about scheduling or rescheduling appointments/questions about time availability/ or cancellations. We cannot ensure confidentiality through phone calls and/or text messages so please keep your voicemails and text messages brief. The only time possible there is to ensure confidentiality is during face-to-face appointments.

If you are unable to reach your counselor and are experiencing a crisis or feel that you cannot wait for a returned phone call, please call 911 or Rescue Mental Health at (419)-255-9585. You may also go to the nearest emergency room and ask for the mental health professional on call. If any of us are unavailable for an extended amount of time, we will provide you with the name of a colleague to contact, if necessary.

Your signature below indicates that you have received the cell-phone disclosure statement and understand the limits to confidentiality when leaving voicemails and sending text messages. Any messages sent via text that do not fall in accordance to the context of this disclosure statement will be charged a rate of $5 per text message, and you will be invoiced for the messages.

Your signature below also indicates that in the event of an emergency where you cannot ensure your own safety, you will call 911 or Rescue Mental Health. If you choose to contact a counselor instead of calling 911 or Rescue Mental Health and we are not able to take your call, you are waving any legal ramifications and cannot hold us responsible in the event you cannot ensure your own safety. This is a legal binding document that is in effect from the date signed below and continues indefinitely.

Signature: _____ Print Name: _____

Witness: _____ Date: _____

INSURANCE, FEES AND OUT OF POCKET RATES FOR PAYMENT

Insurance companies follow strict guidelines set forth by Medicare and Medicaid. In January, 2014, the length of a standard counseling session changed from 60 minutes to 45-51 minutes. We wish to adhere to the guidelines set forth by insurance companies and will bill your insurance accordingly, and as follows:

Assessment	60-75 minutes	$180
Standard Session	45-51 minutes	$120
Non-Standard Session	60 minutes	$150
Reduced Session	30 minutes	$90

The standard fee for a first appointment billed through insurance is $180.00 and the standard fee for ongoing counseling billed through insurance is $120 for a 45-51-minute session. Insurance companies frown upon a Non-Standard Session; however, there are some circumstances where insurance companies will allow a non-standard session, which include crisis stabilization, family counseling, or anything related to decreased functioning related to multiple stressors. Please check with your counselor.

For people who wish to not utilize their insurance benefits, the rate per session in office is $80 for a 60-minute session, $60 for a 45-minute session and $40 for a 30-minute session to be paid after each session. Telephone counseling will be offered at a rate of $40 for 30 minutes, $60 for 45 minutes and $80 for 60 minutes. A credit card authorization will need to be completed and kept on file to be processed after each appointment.

Fees for requests of records, FMLA, SSDI verifications, etc. are additional time outside of the normal therapy visits. For any additional time to compile these items, a charge of $20 will be added to your bill for copies of any records, $50 for processing FMLA and SSDI verifications or any other verifications.

For appearances of the counselor in court, the first day you will be charged $500; $350 for each day thereafter, even if we only attend for 1 hour each day, as we need to adjust our schedules to appear in court and lose other times that we can be seeing clients in the office.

I agree and will adhere to the following:

1) I am responsible for obtaining all authorizations and for all charges not covered. I understand that I am responsible for charges not covered or reimbursed by insurance. I agree, in the event of non-payment, to assume the costs of interest, collection and legal action (if required and waive confidentiality for this purpose).

2) I authorize Jessica Torres-Garcia, LPC or staff to communicate with my insurance company for the purpose of claim verification and authorization for services, including a diagnosis code, and for my insurance carrier to release information regarding my coverage to Jessica Torres-Garcia, LPC and her billing company. I authorize the release of any medical or other information necessary to process this claim.

3) My right to payment for all services are hereby assigned to Jessica Torres-Garcia, LPC. This assignment covers any benefits under Medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect benefits as payment of claims for service. In the event my insurance carrier does not accept Assignment Benefits or if payments are made directly to me, I will endorse payments to Jessica Torres-Garcia, LPC.

4) I authorize Jessica Torres-Garcia, LPC or staff to communicate with its Collection Agency for any and all accounts past due. I authorize the release of my medical information to its Collections Services for the soul purpose of collecting this debt and reporting to the National Credit Reporting Agency. I understand that there will be a 35% fee of the total balance should this account go to collection to offset the fees associated with collecting this debt.

I have read the above statements and accept the terms.

_____ _____

Client Signature or Authorized Persons Signature Date

_____ _____

Witness (Counselor) Date

INVOICING AND PAYMENT

Co-pays and deductible amounts are expected at the time of service. If you are unsure of your copay or deductible, Jessica Torres-Garcia, LPC will allow you to pay your copays through invoicing. When you receive an invoice in the mail for copays and deductibles, it is expected that you will pay within 30 days or contact Jessica Torres-Garcia, LPC to set up a monthly payment plan, no less than $75 per month. A $10 fee for additional invoicing will be charged if payment is not made within the 30 days of your initial invoice. If payment is not made in its entirety after 90 days, your account will go to collection with a 35% fee of your total balance owed for placing your account in collection. It is important that you contact your counselor directly should you have any questions regarding your bill. Your counselor does have the right to call or text you regarding your balance to help you avoid your account going to collection. Please be advised that this is a courtesy phone call or text and not required by your counselor to contact you for payment. Your invoice serves as notice of payment due.

You will receive one (1) invoice for services rendered per each date of service. Payment is due in full, unless payment arrangements are made with your counselor. If you fail to notify your counselor that a payment plan is needed upon receiving your invoice, we will expect payment in full and within 30 days. As you proceed with counseling, you may get multiple invoices for new dates of service, but the same rule applies that payment is due in full unless payment arrangements are made. Payments not received after ninety (90) days without notification of a payment schedule WILL BE SENT TO COLLECTION. We utilize a collection agency who reports to the national credit reporting agencies.

Please be advised that we do charge for a missed appointment without notification by voice mail or text message. **You will be charged an automatic $50 missed appointment fee**. If you decide to keep a credit card on file for your balances, this card will also be used for these fees.

We are also extending the option for our patients to keep a credit card number on file with our office that is authorized for open balances for copays, deductibles and private pays. This is optional and is not required. Though having a credit card on file eliminates monthly invoicing and ensures payment. If you choose this option, your credit card will be billed automatically for any outstanding balance on your account. You may request a summary of your statement at any time from our office.

If you have any questions regarding this policy, please do not hesitate to contact our office. You may also contact our office at any time to place your credit card number on file.

Please choose one of the following options:

____ I will keep a credit card number on file for account balances. (A separate credit card authorization for will need to be filled out.) Ask for form.

____ I do not want to put a credit card on file. I understand the above requirements.

I have read the policy above and agree to invoicing and payment. I may change the option elected above at any time by completing a new form.

_____

Signature

_____

Printed Name

_____ _____

Date Witness or Counselor Date

PRIVATE PAYMENT AGREEMENT

This agreement is for people who have agreed to meet with the counselor for a reduced rate in order to receive services. The following are the costs:

$80 for a 60-minute session
$70 for a 50-minute session
$65 for a 40-minute session

I agree and will adhere to the following:

I will pay by cash or keep a credit card authorization on file for the above services and will pay at the end of each session.

THIS AGREEMENT CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING.

I have read the above statements and accept the terms.

_____ _____
Client Signature or Authorized Persons Signature Date

_____ _____
Witness (Counselor) Date

INVOICING AND PAYMENT

Co-pays and deductible amounts are expected at the time of service. If you are unsure of your copay or deductible, Jessica Torres-Garcia, LPC, will allow you to pay your copays through invoicing. When you receive an invoice in the mail for copays and deductibles, it is expected that you will pay within 30 days or contact Jessica Torres-Garcia, LPC, to set up a monthly payment plan, no less than $75 per month. Failure to pay the invoice could result in collection practices.

You will receive one (1) invoice for services rendered per each date of service. Payment is due in full, unless payment arrangements are made with your counselor. Payment plans will not exceed six (6) months. If you fail to notify your counselor that a payment plan is needed upon receiving your invoice, we will expect payment in full and within 30 days. As you proceed with counseling, you may get multiple invoices for new dates of service, but the same rule applies that payment is due in full unless payment arrangements are made. Payments not received after thirty (30) days without notification of a payment schedule WILL BE SENT TO COLLECTION. We utilize Grace Recovery Services who reports to the national credit reporting agencies.

We are also extending the option for our patients to keep a credit card number on file with our office that is authorized for open balances for copays, deductibles and private pays. This is optional and is not required. Though having a credit card on file eliminates monthly invoicing and ensures payment. If you choose this option, your credit card will be billed automatically for any outstanding balance on your account. You may request a summary of your statement at any time from our office.

Please be advised that we do require 4-hour notice for canceling an appointment. We have voicemail and text options available 24 hours a day, 7 days a week. You will be charged $80.00 for any missed appointment or $20 for late cancelation. In addition, should your counselor have to cancel your appointment without a 4-hour notice, you will be given a $20 credit or should your counselor miss your meeting, you will receive a $80 credit or a free session. If you decide to keep a credit card on file for your balances, this card will also be used for these fees. *Appointments cancelled due to inclement weather or medical emergency will be allowed. *

If you have any questions regarding this policy, please do not hesitate to contact our office. You may also contact our office at any time to place your credit card number on file.

Please choose one of the following options:

____ I will keep a credit card number on file for account balances. (A separate credit card authorization for will need to be filled out.) Ask for form.

____ I do not want to put a credit card on file. I understand the above requirements.

I have read the policy above and agree to invoicing and payment. I may change the option elected above at any time by completing a new form.

_____

Signature

_____

Printed Name

_____ _____

Date Witness or Counselor Date

Information for Treatment and Healthcare Operations

I understand that as a part of my healthcare or the healthcare of my minor child, we originate and maintain health records for describing my health history, symptoms, test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the health professionals who contribute to my care.
- A source of information for applying my diagnosis and treatment information to my bill.
- A means by which a third party payer can verify that services billed were actually provided.
- A tool for routing healthcare operations such as assessing the quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a HIPAA Privacy Notice that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the practice reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations that the practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the practice has already taken action in reliance thereon.

- I request the following restrictions to the use or disclosure of my health information.

_____

_____

Signature of Patient of Legal Representative: _____

Date: _____ Witness Signature: _____Date: _____

THE ATTACHED HIPAA FORM IS YOURS TO KEEP.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL AND DRUG/ALCOHOL RELATED INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED ANDHOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

General Information

Information about your treatment and care, including payment for care is protected by two federal laws: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Confidentiality Law. Under these laws the program may not say to a person outside of the program that you attend the program, nor may the program disclose any information identifying you as an alcohol or drug abuser, or disclose any other protected information except as permitted by the federal laws referred below. The program must obtain your written consent before it can disclose information about you for payment purposes. For example, the program must obtain your written consent before it can disclose information to your health insurer in order to be paid for services. Generally, you must also sign a written consent before the program can share information for treatment purposes or for health care operations. However, federal law permits the program to disclose information in the following circumstances without your written permission:

1. To program staff for the purposes of providing treatment and maintaining the clinical record;
2. Pursuant to an agreement with a business associate (e.g. clinical laboratories, pharmacy, record storage services, billing services);
3. For research, audit or evaluations (e.g. state licensing review, accreditation, and program data reporting as required by state and or federal government);
4. To report a crime committed on the program's premises or against program personnel;
5. To personnel in a medical/psychiatric emergency;
6. To appropriate authorities to report suspected child abuse or neglect, elder abuse or neglect and/or abuse involving a mentally retarded/developmentally disabled person;
7. To report certain infectious illnesses as required by state law;
8. As allowed by a court order;
9. For payment;
10. To report a serious threat to health or safety.

Before the program can use or disclose any information about your health in a manner which is not described above, it must first obtain your specific written consent allowing it to make the disclosure. Any such written consent may be revoked by you in writing. *NOTE: Revoking consent to disclose information to a court, probation department, parole office, etc. may violate an agreement that you have with that organization. Such a violation may result in legal consequences for you. *

- Under HIPAA, you have to request restrictions on certain uses and disclosure of your health and treatment information. The program is not required to agree to any restrictions that you request, but if it does agree with them, it is bound by that agreement and may not use or disclose any information which you have restricted except as necessary in a medical emergency.
- You have the right to request that we communicate with you by alternative means or at an alternative location (e.g. another address). The program will accommodate such requests that are reasonable and will not request an explanation from you.
- Under HIPAA, you also have the right to inspect and copy your own health and treatment information maintained by the program, except to the extent that the information contains psychotherapy notes or information compiled for use in a civil, criminal or administrative proceeding or in other limited circumstances. You must make your request in writing. The Privacy Officer will respond within 30 days of receiving your written request. You may receive a copy of these records but may charge up to $4.00 per page. Instead of providing the health information you requested, you may be provided with a summary or explanation of the information as long as you agree to this and to the cost in advance. In certain situations, your request may be denied. If so, you will receive a letter with the reasons for the denial and your right to have the denial reviewed.
- Under HIPAA, you also have the right with some exceptions to amend health care information maintaining in the program's records and to request and receive an accounting of disclosures of your health-related information made by the program during the six (6) years prior to your request.
- If your request to any of the above is denied, you have the right to request a review of the denial by the program administrator.
- To make any of the above requests, you must fill out the appropriate form that will be provided by program.

- You also have the right to receive a paper copy of this notice.

The Program's Duties
The program is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. The program is required by law to abide by the terms of this notice. The program reserves the right to change the terms of this notice and to make new notice provisions effective for all protected health information it maintains. The program will provide current patients with an updated notice and will provide affected former patients with new notices showing substantive changes are made in the notice.

Complaints and Reporting Violations
You have the right to a copy of this notice and you have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with Jessica Torres-Garcia, LPC and with the Secretary of the Department of Health and Human Services at 200 Independence Avenue SW, Washington DC 20201. All complaints must be in writing. Filing a complaint will not change the health care the program provides. Also, you may have other rights, which are granted to you by state laws and these may be the same or different from the rights described above. The privacy Officer will be happy to discuss these situations with you not or as they arise.

If you Have Questions or Problems
If you need more information or have questions about the privacy practices described above, please speak to the Privacy Officer. If you have a problem with how your PHI has been handled or if you believe your privacy rights have been violated, contact the Privacy Officer. You have the right to file a complaint with the Privacy Officer and with the Secretary of the Federal Department of Health and Human Services. This will not affect your care or will any actions be taken against you if you complain. If you have any questions regarding this notice or health information privacy policies, please contact (419) 540-1902 or in writing at 5647 Mayberry Square East, Sylvania, Oh 43560.

Privacy Officer
Pursuant to 45 CFR 164.560(a)(1)(i), Jessica Torres-Garcia, LPC is hereby designated as the privacy officer for this practice and such individual shall be responsible for developing and implementing this entity's health care privacy policies and procedures, including but not limited to receiving and handling patient requests for restrictions on uses and disclosure of protected health information (PHI) patient request to inspect and receive a copy of their PHI, patients request to receive account of disclosures and patent request to amend their PHI.

Contact Person
Pursuant to 45 CFR164.530(a)(1)(ii), Jessica Torres-Garcia, LPC is hereby designated as the Contact Person for this practice and such individual shall be responsible for receiving complaints from patients concerning possible violations of their privacy rights.
*42 U.S.C. 130d et. Seq. 45 C.F.R. Parts 160 and 164** 42 U.S.C. 290dd-2 C>R.R. Part 2

- Confidentiality: The therapeutic relationship is based on confidentiality. Neither the therapist/supervisor, nor any employee will divulge information about any patient without patient's written consent with the following exceptions:

- When required by the individuals insurance, the patient having signed a waiver when signing the insurance.
- 1) The client is a danger to self or others.
- 2) Suspected child abuse or elder abuse or individuals with a known disability.
- 3) A Subpoena or other court order is received (note: minimal information will be shared to protect your privacy).
- Also, note it is your right to have your information shared with who you request. However, I will need a release of information from you (ROI).

Consent to Share with Supervisor

I hereby voluntarily consent to allow Jessica Torres-Garcia, LPC to share information about me for the sole purpose of supervision for requirements by the State of Ohio Counselor, Social Worker, Marriage and Family Board, in accordance with Rule 4757-23-01, social work supervision.

_____ _____

Client Signature Date

Informed Consent to Receive Mental Health Treatment

I, _____ hereby voluntarily consent to, and authorize us to render mental health treatment to myself and /or minor child. The treatment plan and/or form of treatment to occur will be discussed with me. I understand that I can, at any time, withdraw my consent in writing.

_____ _____

Patient Signature (or parent if patient is a minor) Date

_____

Witness